

2010 Military Health System Conference

Paying for Performance on the Medical Home Model

Sharing Knowledge: Achieving Breakthrough Performance

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Paying for Performance on the Medical Home Model



- Definition
 - The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults.
 - The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

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- Joint principals of PCMH
 - Personal Physician
 - Each patient has an ongoing relationship with a personal physician (provider) trained to provide first contact, continuous and comprehensive care.
 - Physician directed medical practice
 - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of the patient.

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- Joint principals of PCMH
 - Whole person orientation
 - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified individuals.
 - This includes care at all stages of life: acute care, chronic care, preventive services; and end of life care.

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- Joint principals
 - Care is coordinated and/or integrated
 - Across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
 - Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

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- Joint principals of PCMH
 - Quality and safety are the hallmarks of the medical home
 - Practices advocate for their patients to support the attainment of optimal, patient centered outcomes defined by a care planning process driven by compassionate, robust partnership between physicians, patients and the patient's family.

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- Joint principals of PCMH
 - Quality and safety
 - Evidence-based medicine and clinical decision-support tools guide decision making.
 - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
 - Patients actively participate in decision-making and feedback is sought to ensure the patients' expectations are being met.

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- Joint principals of PCMH
 - Quality and safety
 - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication.
 - Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

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- Joint principals of PCMH
 - Quality and safety
 - Patients and families participate in quality improvement activities at the practice level.
 - Enhanced access
 - to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

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- Joint principals of PCMH
 - Payment
 - Appropriately recognizes the added value provided to patients who have a patient-centered medical home.
 - Payment structure should be based on the following framework:
 - Work that falls outside of the face to face visit.
 - Pay for services associated with coordination of care within a practice and between consultants, ancillary providers and community resources.

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- Joint principals of PCMH
 - Payment
 - Should support adoption and use of health information technology for quality improvement.
 - Should support provision of enhanced communication access such as secure email and telephone communication.
 - Should recognize the value of physician work associated with remote monitoring of clinical data using technology.

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- Joint principals of PCMH
 - Payment
 - Should allow for separate fee for service payments for face to face visits. (Payments for care management services that fall outside of the face-to-face visits should not result in a reduction in the payments for face-to-face visits)
 - Should recognize case mix differences in the patient population being treated within the practice.

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- Joint principals of PCMH
 - Payment
 - Should allow physicians to share in savings from reduced hospitalization associated with physician guided care management in an office setting.
 - Should allow for additional payments for achieving measurable and continuous quality improvements.

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- Many health care organizations and professional associations see the primary care medical home as a vital component of primary care renewal.
- One of the major barriers to the implementation of the medical home model is the current reimbursement structure.

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- History and problem
 - Medicare is the single largest purchaser of health care in the United States and serves as the standard for health plan payment policies in the private sector.

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- Examples of Medicare policies that adversely affect the ability of primary care physicians to coordinate their patients' care and work in partnership with them to achieve the best outcomes include:
 - Payment system rewards physicians for increasing the volume of visits and procedures.
 - Payment structure does not provide incentives for physicians to coordinate care.

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- Examples of Medicare policies that adversely affect the ability of primary care physicians to coordinate their patients' care and work in partnership with them to achieve the best outcomes include:
 - No mechanism for physicians to share in the savings that physician-guided care coordination activities generate in other areas of Medicare.
 - The flawed sustainable growth rate (SGR) formula.

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- Solution:
 - Physician payment reforms are needed that adequately compensate primary care physicians to provide patient focused, coordinated care and acquire the health information technology necessary to provide such care. Payment reforms will support physicians in delivering this type of care through the Patient Centered Medical Home (PCMH).

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- What is a patient centered medical home?
 - An innovative model for delivering care to improve quality, promote efficiency, and increase patient and physician practice satisfaction.
 - Physicians providing services under the PCMH model would engage in the following practices:

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- Primary care physicians would be responsible for partnering with the patient to assure their care is managed and coordinated effectively.
- Use innovative scheduling systems to minimize delays in getting appointments.
- Use evidenced-based clinical decision support tools at the point of care.
- Partner with patients with chronic diseases to manage their own conditions.

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- Provide patient access to non-urgent medical advice through email, telephone consultations and related means.
- Have arrangements with a team of health care professionals to provide a full spectrum of patient centered services.
- Be accountable for the care they provide, by using health information technology to provide regular reports of quality, efficiency, and patient experience measures.

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Barriers to Success of Medical Home

- Resistance to collaboration
- Lack of uncertainty of public and political support
- Difficulty controlling costs

Approaches to Overcoming Barriers

- Share information among providers
- Establish performance measurements and rewards
- Institute broad accountability for population based costs

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- A better payment model designed to support care provided by a PCMH:
 - Pay physicians for the time spent to coordinate care with family caregivers and other health professionals.
 - Create financial incentives for physicians to acquire and use health information technology.

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- A better payment model designed to support care provided by a PCMH:
 - Result in higher payments to primary care physicians based on achieving better outcomes and reducing total health care spending.
 - Provide accountability and transparency for achieving better results using evidence based measures.

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- How could services provided in a PCMH be compensated for?
 - A prospective per patient, per month, bundled care coordination component.
 - A fee for service payment for face-to-face encounters with patients.
 - A performance based component based on achievement of defined quality and cost effectiveness goals as reflected on evidenced-based quality, cost of care and patient care experiences.

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- This proposed PCMH payment framework will result in better value:
 - Defined as better outcomes at less cost – for patients and consumers and for employers and governments that purchase health care on their behalf.
 - Recognizing the higher quality and cost savings associated with having a primary care physician who is accountable for the patient's whole health.

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- This proposed PCMH payment framework will result in better value:
 - By rewarding physicians for prevention and coordination rather than volume of services.
 - By facilitating the use of health information technologies to achieve better outcomes and introducing transparency and accountability for care provided,

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- Pay for performance has the potential to help improve the quality of care, if it can be aligned with the goals of the medical profession.
- The primary focus of the quality movement in health care should not be on “pay for” or “performance” based on limited measures, but rather on the patient.